

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-011453

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1630

STATE FILE NUMBER

FILED APR 5 1962

1. PLACE OF DEATH

a. COUNTY

Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR  
TOWN  
Kansas CityLength of stay in 1b  
6 years2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Missouri b. COUNTY Jacksonc. CITY  
OR  
TOWN  
Kansas CityInside Limits  
Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR  
INSTITUTION  
3308 HolmesInside Limits  
Yes ☒ No ☐d. STREET  
ADDRESS  
(If outside, give location)  
3308 HolmesReside on Farm  
Yes ☐ No ☒3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

ELBA

D.

WATSON

4. DATE  
OF  
DEATH

Month

Day

Year

March

19,

1962

5. SEX  
Male6. COLOR OR RACE  
White7. Married ☐ Never Married ☐  
Widowed ☒ Divorced ☐8. DATE OF BIRTH  
9-18-18849. AGE (last birthday)  
77IF UNDER 1 YEAR  
Months DaysIF UNDER 24 HR  
Hours Min.10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)  
Retired10b. KIND OF BUSINESS OR INDUSTRY  
Electrician11. BIRTHPLACE (City and state or country)  
Grant City, Mo.12. CITIZEN OF WHAT COUNTRY  
U.S.A.

13a. FATHER'S NAME

Jujahl Watson

13b. MOTHER'S MAIDEN NAME

Recee Murphin

14. NAME OF HUSBAND OR WIFE

Cora Watson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)  
No

17. INFORMANT

Address

Corrine Watson 3308 Holmes; KCMo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pulmonary embolism

INTERVAL BETWEEN  
ONSET AND DEATH  
MomentsConditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

DUE TO (b)

Phlebothrombosis

Days

DUE TO (c)

Severe congestive heart failure

Weeks

DUE TO (c)

Arteriosclerotic heart disease

Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal  
disease condition given in PART I (a)PART III. If deceased was female was  
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF  
INJURY  
Hour  
a.m.  
p.m.  
Month, Day, Year20d. INJURY OCCURRED  
WHILE AT WORK ☐  
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,  
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from June 7, 1957 to March 19, 1962 and last saw him alive on March 19, 1962

Death occurred at 12:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

4800 East 24th Street

22c. DATE SIGNED

3-20-62

23a. BURIAL, CREMATION,  
REMOVAL (Specify)  
Removal

23b. DATE

3-21-62

23c. NAME OF CEMETERY OR CREMATORY

Grant City Cemetery

23d. LOCATION (City, town, or county)

Grant City, Worth, Missouri

24. FUNERAL DIRECTOR

ADDRESS

Andrews Funeral Home Grant City, Mo.

25. DATE RECD. BY LOCAL REG.

3-21-62

26. REGISTRAR'S SIGNATURE

Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

VS 300  
Rev. 4/59

1

2 3498

3

4 0

5 2

6

7 0

8 2

9 4200

10

11

12 70-0

13

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

R. S. LONG

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*John R. Simon*

Licensed Embalmer No. \_\_\_\_\_

4531

P. O. Address \_\_\_\_\_

*Kansas City, Mo.*

**Note:** The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.